

## FAMILY MEDICAL LEAVE ACT (FMLA) NOTICE OF ELIGIBILITY, RIGHTS, AND DESIGNATION

### Section I – Notice of Eligibility for FMLA Leave – Completed by employee or employer

An employee who notifies an employer of a need for FMLA leave must be given notice within 5 business days of (1) if the employee is eligible for FMLA leave, (2) any further information needed to determine whether the leave sought qualifies under the FMLA, and (3) employees' rights and responsibilities under the FMLA. An employee may complete and submit Section I of this form to their HR Office or the HR Office may complete the form itself upon learning of a leave request.

<b>1. Employee's Name</b>	<b>2. Employee's ID Number</b>	<b>3. Bargaining Unit (if any)</b>
<b>4. Home Address</b>	<b>5. Dates of Leave Requested</b> From: To: <input type="checkbox"/> (Check if intermittent)	<b>6. Telephone Numbers</b> Work Home
<b>7. Reason Leave Requested:</b> On _____ (date) you informed us that you needed leave for: <input type="checkbox"/> A serious health condition that makes you unable to perform the essential functions of your job. <input type="checkbox"/> A serious health condition affecting your <input type="checkbox"/> spouse, <input type="checkbox"/> child, <input type="checkbox"/> parent, for which you are needed to provide care. <input type="checkbox"/> The birth of a child, or the placement of a child with you for adoption or foster care. <input type="checkbox"/> A qualifying exigency arising from the employee's <input type="checkbox"/> spouse, <input type="checkbox"/> child, or <input type="checkbox"/> parent being on active duty or having been notified of a pending call or order to active duty in the Armed Forces in support of a contingency operation. <input type="checkbox"/> To care for a covered servicemember for whom the employee is <input type="checkbox"/> spouse, <input type="checkbox"/> child, <input type="checkbox"/> parent, or <input type="checkbox"/> next of kin.		

### Section II – Eligibility Determination and Required Certifications – Completed by employer

<b>1. Eligibility Determination.</b> <input type="checkbox"/> You are eligible for leave under the FMLA. You appear to be eligible for _____ (remaining time) for the rest of your 12-month FMLA entitlement period ending _____ (date) for <input type="checkbox"/> servicemember family leave <input type="checkbox"/> other FMLA leave. <i>(Complete rest of Section II before signing and providing form to employee.)</i> <input type="checkbox"/> You are not eligible for leave under the FMLA. <i>(Explain why, sign form, and provide to the employee.)</i>
<p>If eligible, you have a right under the FMLA for up to 12 weeks of leave in a 12-month period for the first four qualifying reasons listed in Section I, #7. You also may be eligible for up to 26 weeks of leave in a 12-month period for qualifying care for a covered servicemember, although any other FMLA leave taken during that period will count toward your 26-week entitlement. Your health benefits can be maintained during any period of unpaid FMLA leave as if you continued to work. You must be reinstated to the same or an equivalent job with the same pay, benefits, and conditions of employment on your timely return from leave. You may have other leave options under civil service rules or a collective bargaining agreement. If circumstances change and you can return early, you must notify us at least two work days before you intend to report to work. Clarification and notice of your rights and responsibilities under the FMLA follows:</p>
<b>2. Additional Information.</b> You meet the eligibility requirements, but to determine whether your absence qualifies as FMLA leave, you must return the following information by _____ (date at least 15 calendar days after notice is provided to employee). If sufficient information is not timely provided, your leave may be denied. <input type="checkbox"/> Sufficient certification to support your request for FMLA leave. The enclosed certification form must be returned. <input type="checkbox"/> Sufficient documentation to establish the required relationship between you and your relative. <input type="checkbox"/> No additional information is requested. <input type="checkbox"/> Other information. <i>(Explain information needed.)</i>

<p><b>3. Paid Leave Substitution.</b> You may elect to substitute accrued paid leave for unpaid FMLA leave as provided in your collective bargaining agreement or the civil service rules and regulations. We <input type="checkbox"/> will or <input type="checkbox"/> will not require that you substitute accrued paid leave for unpaid FMLA leave. Any paid leave used counts against your FMLA leave entitlement. The following conditions will apply: <i>(Explain any conditions.)</i></p>
<p><b>4. Insurances.</b> To retain your health, dental, and vision insurance coverage during an unpaid FMLA leave, you must pay any required employee share of the biweekly insurance premiums. You may be required to repay the share of premiums paid by the department to retain your health, dental, and vision coverage if you do not return to employment at the expiration of an FMLA designated unpaid leave for reasons other than continuation, recurrence, or onset of a serious health condition or a covered servicemember's injury or illness or for circumstances beyond your control.</p> <p><input type="checkbox"/> You have a 30-day grace period to make premium payments once you go off the payroll. You must arrange to pay your biweekly share of health, dental, and vision premiums with your HR office. If not timely paid, your coverage will be canceled 15 days after we send written notice that your coverage will lapse.</p> <p><input type="checkbox"/> We will continue coverage and recover your share of health, dental, and vision premiums from you upon your return to work.</p>
<p><b>5. Key Employee.</b> You <input type="checkbox"/> are or <input type="checkbox"/> are not a "key employee," whose restoration to employment may be denied after FMLA leave if restoration will cause substantial and grievous economic injury.</p> <p>We <input type="checkbox"/> have or <input type="checkbox"/> have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm.</p>
<p><b>6. Periodic Reports.</b> While on leave, you <input type="checkbox"/> will or <input type="checkbox"/> will not be required to furnish us with periodic reports every _____ <i>(indicate interval, as appropriate for particular situation)</i> of your status and intent to return to work.</p>
<p><b>7.</b> This form was provided to the employee on _____ <i>(date)</i> by _____ <i>(name)</i> by:</p> <p><input type="checkbox"/> Personal delivery <input type="checkbox"/> First-class mail <input type="checkbox"/> Return receipt requested <input type="checkbox"/> Other _____</p>
<p>After receiving any required information indicated in Section II, #2, your HR Office will respond within 5 business days indicating whether the leave is designated as FMLA leave. This designation will be accomplished by reissuing this form to you with Section III below filled in.</p>
<p><b>Section III – Designation of FMLA Leave – Completed by employer after receiving certification</b></p>
<p><b>1.</b> <input type="checkbox"/> Your requested leave is approved until _____. All leave taken will count against your FMLA entitlement.</p> <p><input type="checkbox"/> The certification you provided is insufficient to determine your eligibility. By _____ <i>(date at least 7 calendar days after notice provided to employee)</i>, you must provide the following or your leave may be denied: <i>(Explain what information is needed to make the certification complete and sufficient below.)</i></p> <p><input type="checkbox"/> We are requiring an additional medical certification at our expense and will provide further details later.</p> <p><input type="checkbox"/> Your requested leave does not meet the requirements for FMLA leave. <i>(Explain why below.)</i></p>
<p><b>2.</b> You <input type="checkbox"/> will or <input type="checkbox"/> will not be required to furnish recertification relating to a serious health condition. <i>(Explain below, including the interval between certifications. See §825.308 of the FMLA regulations for conditions.)</i></p>
<p><b>3.</b> <input type="checkbox"/> If your anticipated leave schedule does not change, _____ will count against your FMLA entitlement.</p> <p><input type="checkbox"/> It is not possible to calculate how much leave will count against your FMLA entitlement now. You have the right to request this information once every thirty days from your HR office.</p>
<p><b>4.</b> You <input type="checkbox"/> will or <input type="checkbox"/> will not be required to present a fitness-for-duty certificate before being restored to employment. If a required certification is not received, your return to work may be delayed until it is provided. If a list of essential functions is attached to this form, your fitness-for-duty certification must address your ability to perform the functions.</p>

If you have questions about your entitlements to FMLA leave, contact \_\_\_\_\_ at \_\_\_\_\_.